

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 27 1959

59-011041

STATE FILING NUMBER  
2 2356

Registration District No.

Primary Registration District No.

Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>4422 Maffitt</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Jackson</b>		4. DATE OF DEATH Month <b>3</b> Day <b>3</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 December 1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service</b>		11. BIRTHPLACE (City and state or country) <b>Nashville Tenn</b>	
13a. FATHER'S NAME <b>Charle Armstrong</b>		14. NAME OF HUSBAND OR WIFE <b>Dead</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>Mrs Clara Scales 915, 14 avenue S. Nashville</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CENEPHIZED ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>450.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>12-3-59</b> to <b>3-3-59</b> and last saw her alive on <b>3-3-59</b> Death occurred at <b>4:45</b> P on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Paul A. Lamm</b> (Degree or title) <b>, M.D.</b>		22b. ADDRESS <b>2601 Whittier Street</b>	
22c. DATE SIGNED <b>3-4-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>3/7/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b>	
24. FUNERAL DIRECTOR <b>Herman J. Smith</b> ADDRESS <b>4247 W Labadie</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 6 '59</b>	
26. REGISTRAR'S SIGNATURE <b>Paul A. Lamm M.D.</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by ....., Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed W. Claude Larkins

Licensed Embalmer No. 3489  
P. O. Address 4575 Alden

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.